# Senate



General Assembly

File No. 42

January Session, 2015

Senate Bill No. 16

Senate, March 10, 2015

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

## AN ACT CONCERNING BENEFITS PAYABLE FOR ASSESSMENTS TO DETERMINE A DIAGNOSIS OF A MENTAL OR NERVOUS CONDITION AND RELATED CONSULTATIONS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

- Section 1. Section 38a-488a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2016*):
- 3 (a) Each individual health insurance policy providing coverage of 4 the type specified in subdivisions (1), (2), (4), (11) and (12) of section 5 38a-469 delivered, issued for delivery, renewed, amended or continued 6 in this state shall provide benefits for the diagnosis and treatment of 7 mental or nervous conditions. For the purposes of this section, "mental 8 or nervous conditions" means mental disorders, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic 10 and Statistical Manual of Mental Disorders". "Mental or nervous 11 conditions" does not include (1) intellectual disabilities, (2) specific 12 learning disorders, (3) motor disorders, (4) communication disorders, 13 (5) caffeine-related disorders, (6) relational problems, and (7) other

conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", except that coverage for an insured under such policy who has been diagnosed with autism spectrum disorder prior to the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders" shall be provided in accordance with subsection (b) of section 38a-488b.

- (b) No such policy shall establish any terms, conditions or benefits that (1) place a greater financial burden on an insured for access to diagnosis or treatment of mental or nervous conditions than for diagnosis or treatment of medical, surgical or other physical health conditions, or (2) limit the number of visits to assess an insured for a diagnosis of a condition.
- (c) In the case of benefits payable for the services of a licensed physician, such benefits shall be payable for the same services when such services are lawfully rendered by a psychologist licensed under the provisions of chapter 383 or by such a licensed psychologist in a licensed hospital or clinic.
- (d) In the case of benefits payable for the services of a licensed physician or psychologist, such benefits shall be payable for the same services when such services are rendered by:
- (1) A clinical social worker who is licensed under the provisions of chapter 383b and who has passed the clinical examination of the American Association of State Social Work Boards and has completed at least two thousand hours of post-master's social work experience in a nonprofit agency qualifying as a tax-exempt organization under Section 501(c) of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as from time to time amended, in a municipal, state or federal agency or in an institution licensed by the Department of Public Health under section 19a-490;

46 (2) A social worker who was certified as an independent social 47 worker under the provisions of chapter 383b prior to October 1, 1990;

- (3) A licensed marital and family therapist who has completed at least two thousand hours of post-master's marriage and family therapy work experience in a nonprofit agency qualifying as a tax-exempt organization under Section 501(c) of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as from time to time amended, in a municipal, state or federal agency or in an institution licensed by the Department of Public Health under section 19a-490;
- 56 (4) A marital and family therapist who was certified under the 57 provisions of chapter 383a prior to October 1, 1992;
- 58 (5) A licensed alcohol and drug counselor, as defined in section 20-59 74s, or a certified alcohol and drug counselor, as defined in section 20-60 74s; or
  - (6) A licensed professional counselor.

- (e) For purposes of this section, [the term "covered expenses"] "benefits payable" means the usual, customary and reasonable charges for treatment deemed necessary under generally accepted medical standards, except [that] in the case of a managed care plan, as defined in section 38a-478, ["covered expenses"] "benefits payable" means the payments agreed upon in the contract between a managed care organization, as defined in section 38a-478, and a provider, as defined in section 38a-478.
- (f) (1) In the case of benefits payable for the services of a licensed physician, such benefits shall be payable for (A) services rendered in a child guidance clinic or residential treatment facility by a person with a master's degree in social work or by a person with a master's degree in marriage and family therapy under the supervision of a psychiatrist, physician, licensed marital and family therapist, or licensed clinical social worker who is eligible for reimbursement under subdivisions (1)

to (4), inclusive, of subsection (d) of this section; (B) services rendered in a residential treatment facility by a licensed or certified alcohol and drug counselor who is eligible for reimbursement under subdivision (5) of subsection (d) of this section; or (C) services rendered in a residential treatment facility by a licensed professional counselor who is eligible for reimbursement under subdivision (6) of subsection (d) of this section.

(2) In the case of benefits payable for the services of a licensed psychologist under subsection (d) of this section, such benefits shall be payable for (A) services rendered in a child guidance clinic or residential treatment facility by a person with a master's degree in social work or by a person with a master's degree in marriage and family therapy under the supervision of such licensed psychologist, licensed marital and family therapist, or licensed clinical social worker who is eligible for reimbursement under subdivisions (1) to (4), inclusive, of subsection (d) of this section; (B) services rendered in a residential treatment facility by a licensed or certified alcohol and drug counselor who is eligible for reimbursement under subdivision (5) of subsection (d) of this section; or (C) services rendered in a residential treatment facility by a licensed professional counselor who is eligible for reimbursement under subdivision (6) of subsection (d) of this section.

(g) In the case of benefits payable for the service of a licensed physician practicing as a psychiatrist or a licensed psychologist, under subsection (d) of this section, such benefits shall be payable for outpatient services rendered (1) in a nonprofit community mental health center, as defined by the Department of Mental Health and Addiction Services, in a nonprofit licensed adult psychiatric clinic operated by an accredited hospital or in a residential treatment facility; (2) under the supervision of a licensed physician practicing as a psychiatrist, a licensed psychologist, a licensed marital and family therapist, a licensed clinical social worker, a licensed or certified alcohol and drug counselor or a licensed professional counselor who is eligible for reimbursement under subdivisions (1) to (6), inclusive, of

subsection (d) of this section; and (3) within the scope of the license

- issued to the center or clinic by the Department of Public Health or to
- the residential treatment facility by the Department of Children and
- 114 Families.
- (h) Except in the case of emergency services or in the case of services
- 116 for which an individual has been referred by a physician affiliated
- with a health care center, nothing in this section shall be construed to
- 118 require a health care center to provide benefits under this section
- through facilities that are not affiliated with the health care center.
- (i) In the case of any person admitted to a state institution or facility
- 121 administered by the Department of Mental Health and Addiction
- 122 Services, Department of Public Health, Department of Children and
- 123 Families or the Department of Developmental Services, the state shall
- have a lien upon the proceeds of any coverage available to such person
- or a legally liable relative of such person under the terms of this
- section, to the extent of the per capita cost of such person's care. Except
- in the case of emergency services, the provisions of this subsection
- shall not apply to coverage provided under a managed care plan, as
- defined in section 38a-478.
- (j) In addition to the requirements set forth in subsections (a) to (g),
- inclusive, of this section, each such policy shall provide benefits for the
- 132 <u>services of a provider specified in subsection (c) or (d) of this section</u>
- for any consultation with such provider that includes the insured or a
- family member of the insured (1) during an assessment for a diagnosis
- of a condition, and (2) after a diagnosis of a mental or nervous
- 136 condition has been made.
- Sec. 2. Section 38a-514 of the general statutes is repealed and the
- following is substituted in lieu thereof (*Effective January 1, 2016*):
- (a) Except as provided in subsection (j) of this section, each group
- 140 health insurance policy, providing coverage of the type specified in
- 141 subdivisions (1), (2), (4), (11) and (12) of section 38a-469, delivered,
- issued for delivery, renewed, amended or continued in this state shall

143 provide benefits for the diagnosis and treatment of mental or nervous 144 conditions. For the purposes of this section, "mental or nervous 145 conditions" means mental disorders, as defined in the most recent 146 edition of the American Psychiatric Association's "Diagnostic and 147 Statistical Manual of Mental Disorders". "Mental or nervous conditions" does not include (1) intellectual disabilities, (2) specific 148 149 learning disorders, (3) motor disorders, (4) communication disorders, 150 (5) caffeine-related disorders, (6) relational problems, and (7) other 151 conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the 152 153 American Psychiatric Association's "Diagnostic and Statistical Manual 154 of Mental Disorders", except that coverage for an insured under such 155 policy who has been diagnosed with autism spectrum disorder prior to 156 the release of the fifth edition of the American Psychiatric Association's 157 "Diagnostic and Statistical Manual of Mental Disorders" shall be 158 provided in accordance with subsection (i) of section 38a-514b.

(b) No such group policy shall establish any terms, conditions or benefits that (1) place a greater financial burden on an insured for access to diagnosis or treatment of mental or nervous conditions than for diagnosis or treatment of medical, surgical or other physical health conditions, or (2) limit the number of visits to assess an insured for a diagnosis of a condition.

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- (c) In the case of benefits payable for the services of a licensed physician, such benefits shall be payable for the same services when such services are lawfully rendered by a psychologist licensed under the provisions of chapter 383 or by such a licensed psychologist in a licensed hospital or clinic.
- (d) In the case of benefits payable for the services of a licensed physician or psychologist, such benefits shall be payable for the same services when such services are rendered by:
- 173 (1) A clinical social worker who is licensed under the provisions of 174 chapter 383b and who has passed the clinical examination of the 175 American Association of State Social Work Boards and has completed

at least two thousand hours of post-master's social work experience in

- a nonprofit agency qualifying as a tax-exempt organization under
- 178 Section 501(c) of the Internal Revenue Code of 1986 or any subsequent
- 179 corresponding internal revenue code of the United States, as from time
- 180 to time amended, in a municipal, state or federal agency or in an
- institution licensed by the Department of Public Health under section
- 182 19a-490;
- 183 (2) A social worker who was certified as an independent social
- 184 worker under the provisions of chapter 383b prior to October 1, 1990;
- 185 (3) A licensed marital and family therapist who has completed at
- least two thousand hours of post-master's marriage and family therapy
- 187 work experience in a nonprofit agency qualifying as a tax-exempt
- organization under Section 501(c) of the Internal Revenue Code of 1986
- or any subsequent corresponding internal revenue code of the United
- 190 States, as from time to time amended, in a municipal, state or federal
- agency or in an institution licensed by the Department of Public Health
- 192 under section 19a-490;
- 193 (4) A marital and family therapist who was certified under the
- 194 provisions of chapter 383a prior to October 1, 1992;
- 195 (5) A licensed alcohol and drug counselor, as defined in section 20-
- 196 74s, or a certified alcohol and drug counselor, as defined in section 20-
- 197 74s; or
- 198 (6) A licensed professional counselor.
- (e) For purposes of this section, [the term "covered expenses"]
- 200 "benefits payable" means the usual, customary and reasonable charges
- 201 for treatment deemed necessary under generally accepted medical
- standards, except [that] in the case of a managed care plan, as defined
- in section 38a-478, ["covered expenses"] "benefits payable" means the
- 204 payments agreed upon in the contract between a managed care
- organization, as defined in section 38a-478, and a provider, as defined
- 206 in section 38a-478.

(f) (1) In the case of benefits payable for the services of a licensed physician, such benefits shall be payable for (A) services rendered in a child guidance clinic or residential treatment facility by a person with a master's degree in social work or by a person with a master's degree in marriage and family therapy under the supervision of a psychiatrist, physician, licensed marital and family therapist or licensed clinical social worker who is eligible for reimbursement under subdivisions (1) to (4), inclusive, of subsection (d) of this section; (B) services rendered in a residential treatment facility by a licensed or certified alcohol and drug counselor who is eligible for reimbursement under subdivision (5) of subsection (d) of this section; or (C) services rendered in a residential treatment facility by a licensed professional counselor who is eligible for reimbursement under subdivision (6) of subsection (d) of this section.

(2) In the case of benefits payable for the services of a licensed psychologist under subsection (d) of this section, such benefits shall be payable for (A) services rendered in a child guidance clinic or residential treatment facility by a person with a master's degree in social work or by a person with a master's degree in marriage and family therapy under the supervision of such licensed psychologist, licensed marital and family therapist or licensed clinical social worker who is eligible for reimbursement under subdivisions (1) to (4), inclusive, of subsection (d) of this section; (B) services rendered in a residential treatment facility by a licensed or certified alcohol and drug counselor who is eligible for reimbursement under subdivision (5) of subsection (d) of this section; or (C) services rendered in a residential treatment facility by a licensed professional counselor who is eligible for reimbursement under subdivision (6) of subsection (d) of this section.

(g) In the case of benefits payable for the service of a licensed physician practicing as a psychiatrist or a licensed psychologist, under subsection (d) of this section, such benefits shall be payable for outpatient services rendered (1) in a nonprofit community mental health center, as defined by the Department of Mental Health and

Addiction Services, in a nonprofit licensed adult psychiatric clinic operated by an accredited hospital or in a residential treatment facility; (2) under the supervision of a licensed physician practicing as a psychiatrist, a licensed psychologist, a licensed marital and family therapist, a licensed clinical social worker, a licensed or certified alcohol and drug counselor, or a licensed professional counselor who is eligible for reimbursement under subdivisions (1) to (6), inclusive, of subsection (d) of this section; and (3) within the scope of the license issued to the center or clinic by the Department of Public Health or to the residential treatment facility by the Department of Children and Families.

(h) Except in the case of emergency services or in the case of services for which an individual has been referred by a physician affiliated with a health care center, nothing in this section shall be construed to require a health care center to provide benefits under this section through facilities that are not affiliated with the health care center.

- (i) In the case of any person admitted to a state institution or facility administered by the Department of Mental Health and Addiction Services, Department of Public Health, Department of Children and Families or the Department of Developmental Services, the state shall have a lien upon the proceeds of any coverage available to such person or a legally liable relative of such person under the terms of this section, to the extent of the per capita cost of such person's care. Except in the case of emergency services the provisions of this subsection shall not apply to coverage provided under a managed care plan, as defined in section 38a-478.
- (j) A group health insurance policy may exclude the benefits required by this section if such benefits are included in a separate policy issued to the same group by an insurance company, health care center, hospital service corporation, medical service corporation or fraternal benefit society. Such separate policy, which shall include the benefits required by this section and the benefits required by section 38a-533, shall not be required to include any other benefits mandated

by this title.

(k) In the case of benefits based upon confinement in a residential treatment facility, such benefits shall be payable in situations in which the insured has a serious mental or nervous condition that substantially impairs the insured's thoughts, perception of reality, emotional process or judgment or grossly impairs the behavior of the insured, and, upon an assessment of the insured by a physician, psychiatrist, psychologist or clinical social worker, cannot appropriately, safely or effectively be treated in an acute care, partial hospitalization, intensive outpatient or outpatient setting.

(l) The services rendered for which benefits are to be paid for confinement in a residential treatment facility shall be based on an individual treatment plan. For purposes of this section, the term "individual treatment plan" means a treatment plan prescribed by a physician with specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

(m) In addition to the requirements set forth in subsections (a) to (g), inclusive, and subsections (k) and (l) of this section, each such policy shall provide benefits for the services of a provider specified in subsection (c) or (d) of this section for any consultation with such provider that includes the insured or a family member of the insured (1) during an assessment for a diagnosis of a condition, and (2) after a diagnosis of a mental or nervous condition has been made.

This act shall take effect as follows and shall amend the following sections:						
Section 1	January 1, 2016	38a-488a				
Sec. 2	January 1, 2016	38a-514				

#### INS Joint Favorable

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

### **OFA Fiscal Note**

## State Impact:

Agency Affected	Fund-Effect	FY 16 \$	FY 17 \$
State Comptroller - Fringe	GF, TF - Cost	\$25,000	\$50,000
Benefits (State Employee and			
Retiree Health Accounts)			
The State	Indeterminate -	\$12,300	\$24,700
	Cost		

GF & TF = General Fund and Special Transportation Fund

## Municipal Impact:

Municipalities	Effect	FY 16 \$	FY 17 \$
Various Municipalities	STATE	\$15,000	\$30,000
_	MANDATE		
	- Cost		

### Explanation

The bill will result in a cost to the state employee and retiree health plan<sup>1</sup>, municipalities, and the state, related to an increase in psychological and neuropsychological testing from prohibiting a limit on the number of diagnostic assessments. The total estimated cost to the state in FY 16 is approximately \$37,300 and \$74,700 in FY 17. This cost is attributable to (1) the estimated cost to the state plan in FY 16 and FY 17 of approximately \$25,000 and \$50,000 respectively and (2) the cost to the state pursuant to the federal Affordable Care Act (ACA) (see below) in FY 16 and FY 17 of approximately \$12,300 and \$24,700 respectively. The cost to fully insured municipalities in FY 16 and FY

<sup>&</sup>lt;sup>1</sup> The state employee and retiree health plan is a self-insured health plan. Pursuant to federal law, self-insured health plans are exempt from state health mandates. However, the state has traditionally adopted all state health mandates.

17 is approximately \$15,000 and \$30,000 respectively.<sup>2</sup>

If adopted by the state plan, the actual cost to the plan will depend on the utilization of services by the plan's population. The cost to the state pursuant to the ACA may be underrepresented as it is uncertain at this time if the enrollment information reported reflects the total number of covered lives by exchange plans or the number of individuals who purchased a policy.

## **Municipal Impact**

As previously stated, the bill may increase costs to certain fully insured, municipal plans that limit the number of assessment visits. The coverage requirements may result in increased premium costs when municipalities enter into new health insurance contracts after January 1, 2016. In addition, many municipal health plans are recognized as "grandfathered" health plans under the ACA.³ It is unclear what effect the adoption of certain health mandates will have on the grandfathered status of certain municipal plans under ACA. Pursuant to federal law, self-insured health plans are exempt from state health mandates.

#### The State and the federal ACA

Lastly, the ACA requires that, the state's health exchange's qualified health plans (QHPs)<sup>4</sup>, include a federally defined essential health benefits package (EHB). The federal government is allowing states to choose a benchmark plan<sup>5</sup> to serve as the EHB until 2016 when the

<sup>&</sup>lt;sup>2</sup> The estimated cost is based on the per member per month (PMPM) impact of \$.02. The cost estimate for the state employee plan is based on the plan membership as of January 2015; municipal impact is based on Dept. of Labor employment information as of December 31, 2014; state impact based on Exchange enrollment is as of February 2015. Exchange enrollment excludes Medicaid enrollees totaling 382,021.

<sup>&</sup>lt;sup>3</sup> Grandfathered plans include most group insurance plans and some individual health plans created or purchased on or before March 23, 2010.

<sup>&</sup>lt;sup>4</sup> The state's health exchange, Access Health CT, opened its marketplace for Connecticut residents to purchase QHPs from carriers, with coverage starting January 1, 2014.

<sup>&</sup>lt;sup>5</sup> The state's benchmark plan is the Connecticare HMO plan with supplemental coverage for pediatric dental and vision care as required by the ACA.

federal government is anticipated to revisit the EHB.

While states are allowed to mandate benefits in excess of the EHB, the federal law requires the state to defray the cost of any such additional mandated benefits for all plans sold in the exchange, by reimbursing the carrier or the insured for the excess coverage. State mandated benefits enacted after December 31, 2011 cannot be considered part of the EHB for 2014-2015 unless they are already part of the benchmark plan.<sup>6</sup> However, neither the agency nor the mechanism for the state to pay these costs has been established.

#### The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to 1) medical inflation, 2) the number of covered lives in the state, municipal and exchange health plans, and 3) the utilization of services.

Sources: Department of Labor

Office of the State Comptroller

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<sup>&</sup>lt;sup>6</sup> Source: Dept. of Health and Human Services. Frequently Asked Questions on Essential Health Benefits Bulletin (February 21, 2012).

OLR Bill Analysis SB 16

AN ACT CONCERNING BENEFITS PAYABLE FOR ASSESSMENTS TO DETERMINE A DIAGNOSIS OF A MENTAL OR NERVOUS CONDITION AND RELATED CONSULTATIONS.

#### **SUMMARY:**

This bill expands coverage under certain health insurance policies for the assessment and diagnosis of mental or nervous conditions by prohibiting insurers from limiting the number of visits to assess an insured for such a diagnosis (see BACKGROUND).

The bill requires insurers to cover consultations during an assessment and after a diagnosis between an insured, or his or her family member, and a licensed physician, psychologist, clinical social worker, marital and family therapist, or professional counselor. The bill also covers consultations with certain certified marital and family therapists, independent social workers, and licensed or certified alcohol and drug counselors. (The bill does not define the terms "consultation" or "family member".)

The bill also substitutes the term "benefits payable" for "covered expenses" as it pertains to the mental or nervous conditions benefit mandate. By law, these are the usual, customary, and reasonable charges for medically necessary treatment or, in the case of a managed care plan, the contracted rates.

The bill applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, or (4) hospital or medical services, including those provided under an HMO plan. Due to the federal Employee Retirement Income Security Act, state insurance mandates

do not apply to self-insured benefit plans.

EFFECTIVE DATE: January 1, 2016

#### **BACKGROUND**

#### Mental or Nervous Conditions

By law, "mental or nervous conditions" are mental disorders defined in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM). This does not include (1) intellectual disabilities, (2) specific learning disorders, (3) motor disorders, (4) communication disorders, (5) caffeine-related disorders, (6) relational problems, and (7) other conditions that may be a focus of clinical attention but are not defined as mental disorders in the DSM (CGS § 38a-488a).

#### Related Federal Law

Under the federal Patient Protection and Affordable Care Act (P.L. 111-148), a state may require health plans sold through the state's health insurance exchange to offer benefits beyond those included in the required "essential health benefits," provided the state defrays the cost of those additional benefits. The requirement applies to benefit mandates enacted by a state after December 31, 2011. Thus, the state is required to pay the insurance carrier or enrollee to defray the cost of any new benefits mandated after that date.

## **COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable Yea 12 Nay 3 (02/26/2015)